NCQA's Patient-Centered Medical Home Recognition and Beyond

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NCQA
Measuring quality.
Improving health care.

National Committee for Quality Assurance (NCQA)

Private, independent non-profit health care quality oversight organization founded in 1990

MISSION

To improve the quality of health care.

VISION

To transform health care through quality measurement, transparency, and accountability.

ILLUSTRATIVE PROGRAMS

*** HEDIS® – Healthcare Effectiveness Data and Information Set**

*** Health Plan Accreditation * Clinician Recognition**

*** Disease Management Accreditation * Wellness & Health Promotion Accreditation**

*** Quality Compass™**

We need accountability at all levels

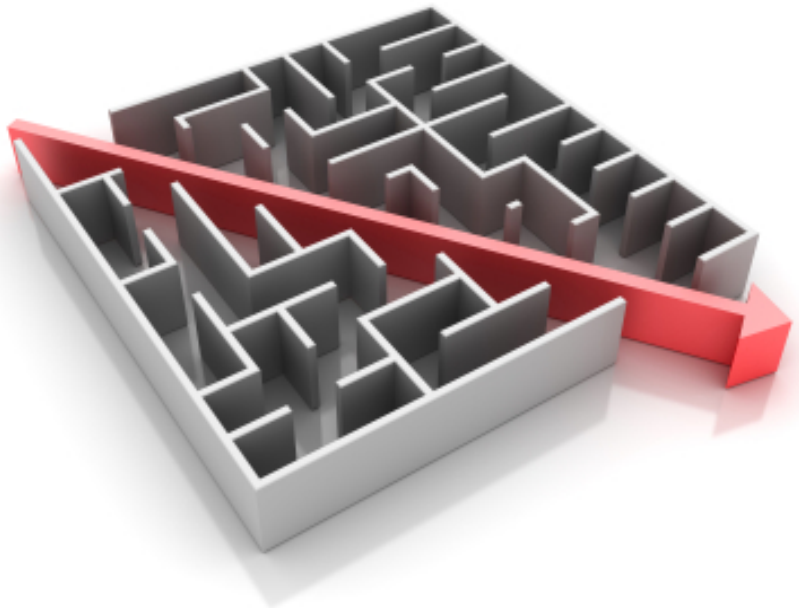
- **Health plans**
- **ACOs, organized delivery systems**
- **Practices**
- **Integration can be achieved by cooperation across levels**
- **Ultimately, payment reform is necessary to achieve quality, affordable care**

A 2020 vision of patient-centered primary care

- **Superb access to care**
- **Consumer engagement in health and care**
- **Clinical information systems that support high-quality care, practice-based learning, and quality improvement**
- **Care coordination**
- **Integrated and comprehensive team care**
- **Routine feedback to clinicians**
- **Publically available information**

(Davis, et al, 2005)

PCMH is a first step in health system integration



- Previous initiatives worked around (not with) delivery system
- Providers want to be engaged, think strategically
- Aligns with primary care specialty societies, aided by Wagner Model

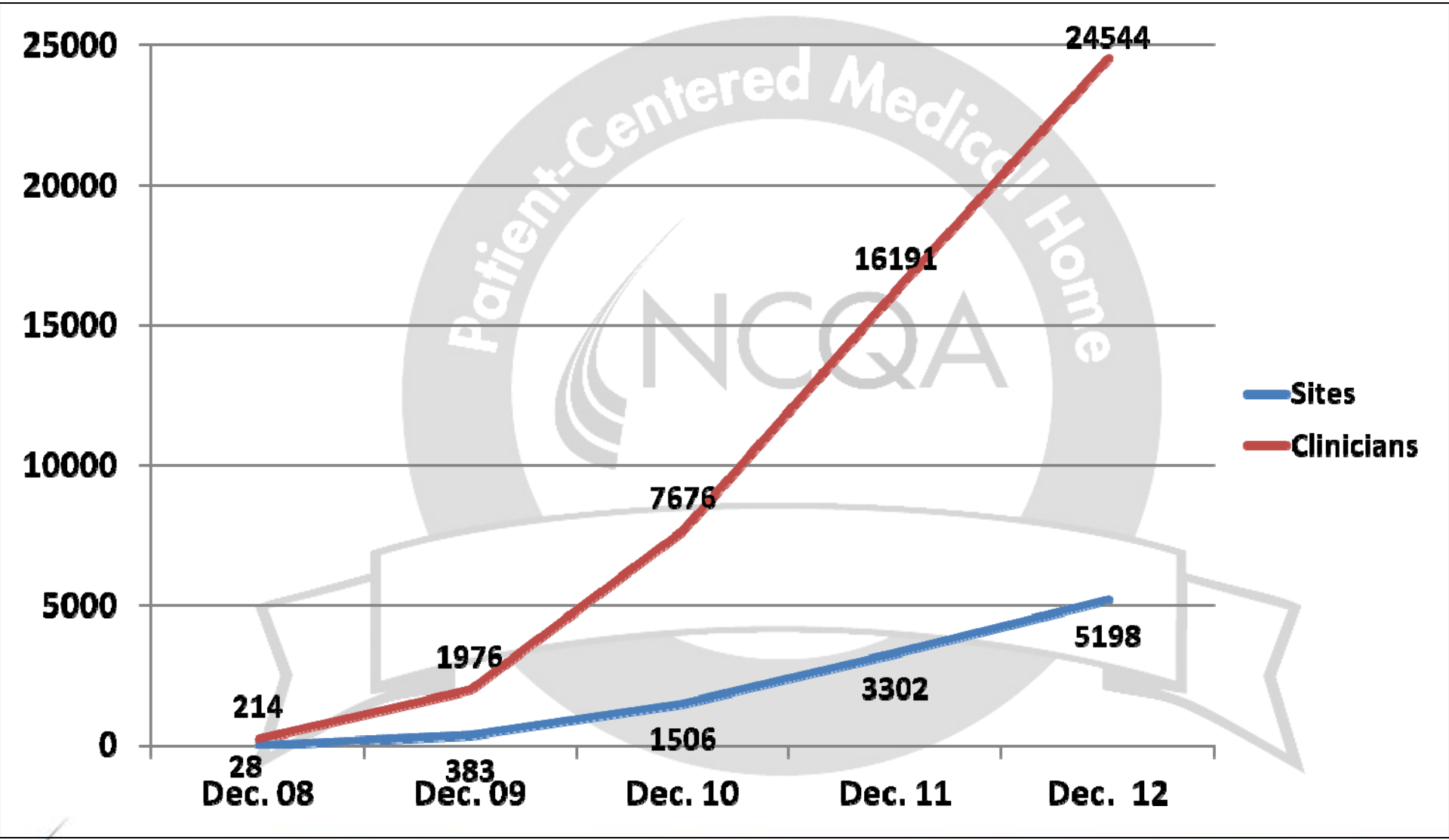
What is a Patient-Centered Medical Home?

- **Each Patient has a Personal Clinician** – providing first contact and continuous and comprehensive care, leading a care team taking responsibility for the ongoing care of patients.
- **The Practice Takes on a Whole Person Orientation for All its Patients** – providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.
- **Patient Care is Coordinated** - assuring that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner, facilitated by information technologies, health information exchange and other means.

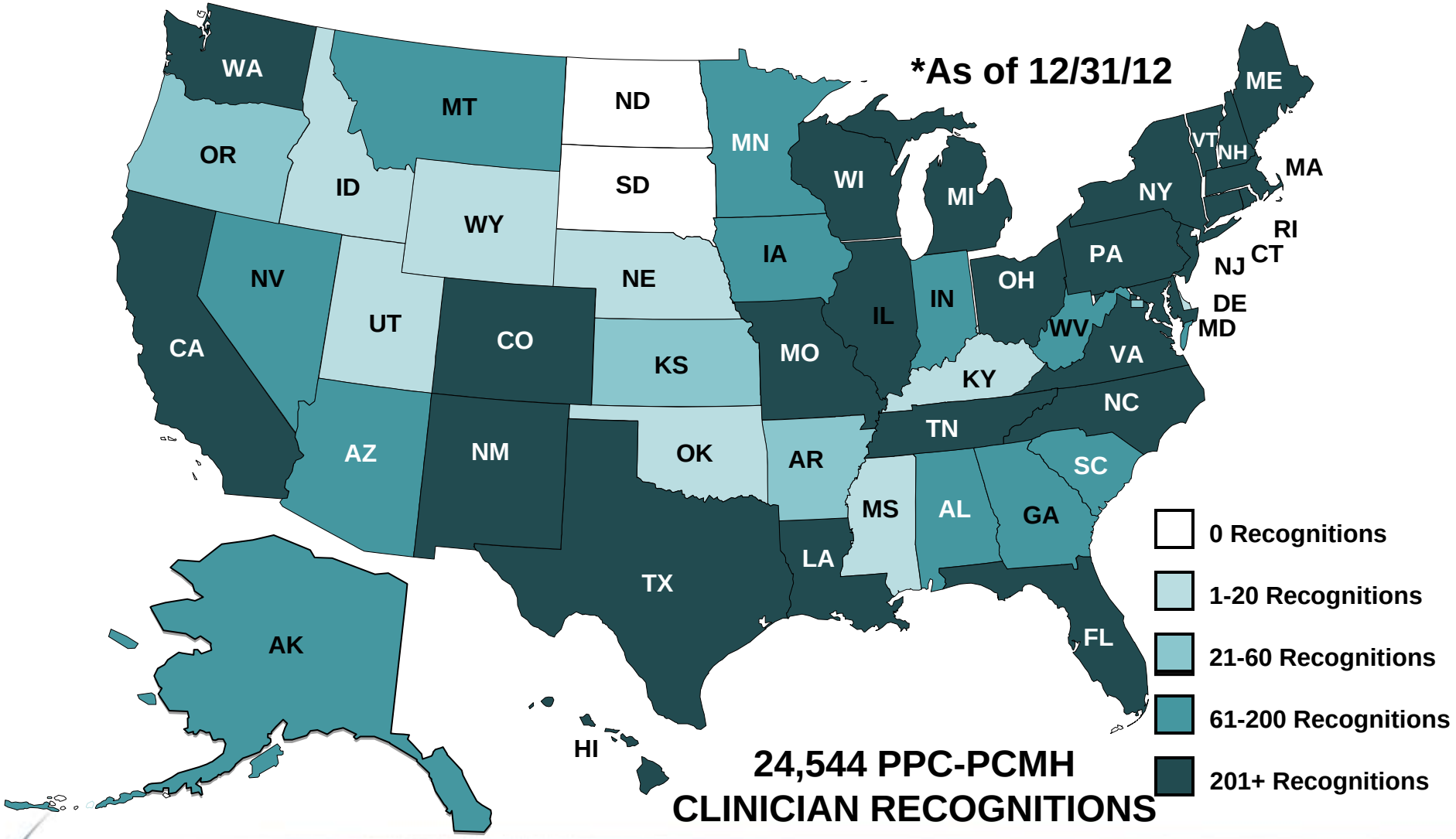
Why NCQA?

- **Long-standing commitment to population health; measurement; improvement**
- **Experience**
- **Expertise**
- **Education & Support**
- **Flexibility**
- **Widely adopted**

PCMH is the fastest-growing delivery system improvement



NUMBER OF PPC-PCMH & PCMH CLINICIAN RECOGNITIONS BY STATE



PPC-PCMH/PCMH Practices*

NUMBER OF CLINICIANS IN RECOGNIZED PRACTICES

	1-2	3-7	8-9	10-19	20-50	50+	Total
Level 1	465	333	34	48	6	0	**886**
Level 2	152	145	19	26	2	0	**344**
Level 3	1461	1794	262	343	100	8	**3968**
Total	**2078**	**2272**	**315**	**417**	**108**	**8**	**5198**

*** As of 12/31/12**

Payers Using Recognition

- **At least 36 plans in 27 states pay rewards or supplement application fees for recognition**
  - **Aetna, Cigna and United use recognition for entry into high-performance networks**
  - **Aetna, BCBSA, BCBS Western NY, BCBS Northeastern NY, CIGNA, Capital District Physicians Health Plan, Highmark BCBS, Humana, United and others add Recognition seals to provider directories (list available on NCQA.org)**
- **At least 20 states use NCQA recognition in their initiatives**
- **HRSA & CMS support CHCs with assistance and payment**
- **Military Health System is transforming treatment facilities using the model and supporting practices in becoming recognized (153 sites in 2011/12, 180 scheduled in 2013)**

PCMH Development History

- **10 years of evolution**
- **Based on a systematic approach to delivering preventive and chronic care (Wagner Chronic Care Model)**
- **Built on IOM's recommendation to shift from "blaming" individual clinicians to improving systems**
- **Identified measures actionable at the practice level**
- **Validated measures by relating them to clinical performance and patient experience results**
- **Incorporated the Joint Principles into PPC-PCMH:**
  - Whole-person focus
  - Coordinated, integrated, comprehensive care
  - Personal clinician, team-based care

Growing Evidence on PCMH

- **PCMH Improves Low-Income Access, Reduces Inequities** Berenson, Commonwealth Fund, May 2012

- **PCMH Improves Quality And Patient Satisfaction, Lowers Costs** PCPCC, September 2012

- **Colorado PCMH Multi-Payer Pilot Reduced Inpatient Admissions, ER Visits & Demonstrated Plan ROI** Harbrecht, September 2012

- ***The Group Health Medical Home At Year Two: Cost Savings, Higher Patient Satisfaction And Less Burnout For Providers*** Soman, Health Affairs, May 2010

Research Shows: Medical Homes *Work*

- **Decrease in acute inpatient admissions, ER visits and overall PMPM cost, improved compliance with evidence-based guidelines and performance on quality measures** Raskas 2012

- **Fewer emergency room visits, hospitalizations and lower overall costs, improved access and performance on key quality indicators**
  Patel 2012, Patient-Centered Primary Care Collaborative 2012

- **Medicaid Pilots: Improved access to care, reduced PMPM/PMPY costs, decreased ER and inpatient utilization, greater use of evidence-based primary care** Takach 2011

Who's Eligible?

- **Recognitions are always awarded on the geographic site level**
- **Clinicians who are eligible**
  - MDs, DOs, NPs, and PAs with panels of primary care patients
  - 75% of their patients come for first contact, comprehensive, continuous PCP care
- **Clinicians who see patients routinely at more than one site should be listed on each site's application**
- **Multi-Sites have:**
  - 3 or more sites
  - The same EMR
  - The same procedures for staff
  - The ability to be bound by a single contract

2011 PCMH Content and Scoring

Standard 1: Enhance Access and Continuity		Pts
A.	**Access During Office Hours****	**4**
B.	After-Hours Access	4
C.	Electronic Access	2
D.	Continuity	2
E.	Medical Home Responsibilities	2
F.	Culturally and Linguistically Appropriate Services	2
G.	Practice Team	4
		20

Standard 2: Identify and Manage Patient Populations		Pts
A.	Patient Information	3
B.	Clinical Data	4
C.	Comprehensive Health Assessment	4
D.	**Use Data for Population Management****	**5**
		16

Standard 3: Plan and Manage Care		Pts
A.	Implement Evidence-Based Guidelines	4
B.	Identify High-Risk Patients	3
C.	**Care Management****	**4**
D.	Medication Management	3
E.	Use Electronic Prescribing	3
		17

Standard 4: Provide Self-Care Support and Community Resources		Pts
A.	**Support Self-Care Process****	**6**
B.	Provide Referrals to Community Resources	3
		9

Standard 5: Track and Coordinate Care		Pts
A.	Test Tracking and Follow-Up	6
B.	**Referral Tracking and Follow-Up****	**6**
C.	Coordinate with Facilities/Care Transitions	6
		18

Standard 6: Measure and Improve Performance		Pts
A.	Measure Performance	4
B.	Measure Patient/Family Experience	4
C.	**Implement Continuously Quality Improvement****	**4**
D.	Demonstrate Continuous Quality Improvement	3
E.	Report Performance	3
F.	Report Data Externally	2
G.	Use of Certified EHR Technology	0
		20

****Must Pass Elements**

PCMH Scoring

6 standards = 100 points
6 Must Pass elements

NOTE: Must Pass elements require a ≥ **50%** performance level to pass

Level of Qualifying	Points	Must Pass Elements at 50% Performance Level
Level 3	85 - 100	6 of 6
Level 2	60 - 84	6 of 6
Level 1	35 - 59	6 of 6
Not Recognized	0 - 34	< 6

Practices with a numeric score of 0 to 34 points and/or achieve less than 6 "Must Pass" Elements are not Recognized.

Recognition is for 3 years. Practices may submit an add-on survey, based on their initial survey, within the 3 year Recognition to achieve a higher level. After 3 years, the practice must submit the survey version available at that time for renewal.

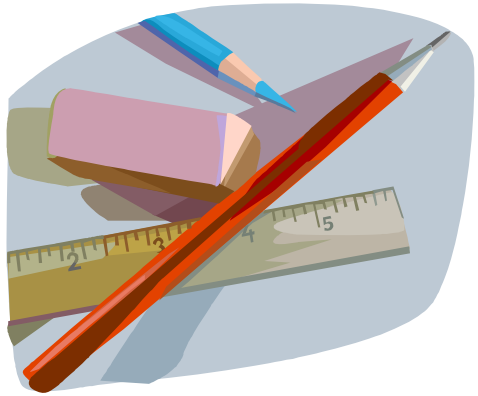
In God We Trust, All Others Must Provide Data

- **While all 6 of the PCMH Must Pass Elements require data for submission, none require the use of an EMR**
- **A practice can achieve PCMH Recognition without an EMR***
- **Assuming the practice utilizes other forms of HIT e.g. Practice Management Systems, eRx, registries**
- **24 of 28 Elements require some quantitative data**

QUALITY IMPROVEMENT IN THE PATIENT-CENTERED MEDICAL HOME

Why Measure Performance?

- **Internal**
  - Assess current performance
  - Demonstrate and verify performance
  - Control performance
- **External**
  - Accountability
  - Decision-making
  - Public reporting
  - Organization evaluation



A Practice is a System

- **Change is easy…but making change stick is hard**
  - For every action there will be a reaction
  - Break down occurs because of failure to consider the human side of change
- **Art of managing change is key**
  - **Technical side of change is important, but the human side is just as vital**
  - **Improvement takes will, ideas and execution**

THE RECOGNITION PROCESS

The NCQA PCMH Recognition Process

Practice:

- **Obtains PCMH 2011 Standards**
- **Participates in NCQA trainings**
- **Obtains survey tool and online application account**
- **Self-assesses current performance on survey**
- **Completes online application information: electronic agreements, practice site, clinician details, and application for survey**
- **Submits application**
- **Receives email confirmation that practice can submit survey tool and documentation**
- **Submits survey tool and application fee when ready**

Overview of Recognition Review Process

NCQA

- **Checks licensure of all clinicians**
- **Evaluates Survey Tool responses, documentation, and explanations by**
  - Reviewer – initial evaluation
  - Executive reviewer – NCQA PCMH managers
  - Peer review – Recognition Program Review Oversight Committee member (RP-ROC)
  - Audit (5%) – by email, teleconference, or on-site audit
- **Issues final decision and level to the practice within 30 – 60 days**
- **Reports results**
  - Recognition posted on NCQA Web site
  - Not passed - not reported
- **Mails PCMH certificate and Recognition packet**

DISTINCTION IN PATIENT EXPERIENCE REPORTING

Why Require CAHPS PCMH Survey?

- **Rigorous development process**
- **Extensive field testing**
- **Medical Home-specific survey**
- **Many practices already use the CAHPS - CG survey; can easily move to use of the PCMH version**
- **Use of a standardized instrument will ultimately allow for comparison of performance across practices**

SUPPORTING THE PCMH INSIDE AND OUT

Building on the Medical Home

- **Resources**
- **PCMH Vendor Prevalidation**
- **November 2011: ACO Accreditation**
- **January 2013: PCMH Content Expert Certification**
- **March 2013: Patient-Centered Specialty Practice Recognition Program**
- **First quarter 2014: New version of the PCMH standards will be released, including Stage 2 Meaningful Use**

PCMH 2011 Prevalidation

- **EHR vendors or service providers can complete an application, sign a program agreement, and submit a PCMH survey for evaluation to earn a score within the PCMH 2011 program if their product(s) provide functionality that completely meet factor level requirements**
- **The approved automatic credit can then be transferred to practices utilizing the prevalidated products functionality, eliminating the provision of documentation for the associated factors within their PCMH survey.**

Scoring

100%	75%	50%	25%	0%
The practice meets all 4 factors	The practice meets 3 factors	The practice meets 2 factors	The practice meets 1 factor	The practice meets no factors

What are ACOs?

- **Provider-based organizations that are accountable for both quality and costs of care for a defined population**
  - Arrange for the total continuum of care
- **Align incentives and reward providers based on performance (quality and financial)**
  - Incentivized through payment mechanisms such as shared savings or partial/full-risk contracts
- **Goal is to meet the "triple aim"**
  - Improve people's experience of care
  - Improve population health
  - Reduce overall cost of care

ACOs and PCMH 2011: NCQA's Perspective

- **Published Standards for ACO Accreditation in 2011**
- **Released HEDIS Measures for ACOs in 2012**
- **Accredited 6 Early Adopters**
- **Concepts and standards from PCMH 2011 are integrated into ACO Criteria**
  - **ACO patient-centered capabilities**
    - Support patient-centered care in medical home
    - Provide resources to other providers in system to support patient-centered care
  - **Primary care capabilities**
    - Medical home functions

PCMH Content Expert Certification

- **Certification awarded to individuals who demonstrate an acceptable level of knowledge of all aspects of the PCMH 2011 Recognition Program**
- **Knowledge demonstrated by achieving a pass scoring on a test administered by an external test vendor**
- **Completion of 2 NCQA seminars required in order to take the exam**
  - Facilitating PCMH Recognition
  - Advanced PCMH: Mastering NCQA's Medical Home Recognition
- **Two year duration; certificate with seal awarded**
- **Certified individuals identified on the NCQA web site as PCMH Certified Content Experts**

PCMH concepts are spreading to "neighbors" outside of primary care

- **NCQA is launching a practice-based recognition for nonprimary care specialties**
- **Program seeks to enhance PCP/Specialist collaboration and coordination to benefit the patient**

Research shows communication must improve

- **Disconnect between PCP and specialist**
- **PCPs report sending information 70% of the time; specialists report receiving information 35% of the time[1]**
- **Specialists report sending a report 81% of the time; PCPs report receiving a report 62% of the time[1]**
- **25%-50% of referring physicians did not know if patients had seen a specialist[2]**

[1] O'Malley, A.S., Reschovsky, J.D. (2011) Referral and consultation communication between primary care and specialist physicians: finding common ground. *Arch Intern Med, 171* (1), 56-65.

[2] Mehrotra, A., Forrest, C.B., Lin, C.Y. (2011). Dropping the Baton: Specialty Referrals in the United States. *The Milbank Quarterly, 89* (1), 39-68.

Patient-Centered Specialty Practice

(6 standards/22 elements)

1. **Track and Coordinate Referrals (22)**
   - **A. *Referral Process and Agreements**
   - B. Referral Content
   - **C. *Referral Response**
2. **Provide Access and Communication (18)**
   - A. Access
   - B. Electronic Access
   - C. Specialty Practice Responsibilities
   - D. Culturally and Linguistically Appropriate Services (CLAS)
   - **E. *The Practice Team**
3. **Identify and Coordinate Patient Populations (10)**
   - A. Patient Information
   - B. Clinical Data
   - C. Coordinate Patient Populations
4. **Plan and Manage Care (18)**
   - A. Care Planning and Support Self-Care
   - **B. *Medication Management**
   - C. Use Electronic Prescribing
5. **Track and Coordinate Care (16)**
   - A. Test Tracking and Follow-Up
   - B. Referral Tracking and Follow-Up
   - C. Coordinate Care Transitions
6. **Measure and Improve Performance (16)**
   - A. Measure Performance
   - B. Measure Patient/Family Experience
   - **C. *Implement and Demonstrate Continuous Quality Improvement**
   - D. Report Performance
   - E. Use Certified EHR Technology

***Must Pass**

Recognition starts with 25 points

NCQA Contact Information

Contact NCQA Customer Support at
1-888-275-7585

Visit NCQA Web Site at www.ncqa.org to:

- ✓ View Frequently Asked Questions
- ✓ View Recognition Programs Training Schedule
- ✓ Acquire standards documents, application account, and survey tools

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